2009-2010 Session
State Legislative End of Session Report as of 10/13/2010

Overview of Priority Board Bills

AB 342 (Perez) Medi-Cal: Demonstration Project Waivers
This bill has been enrolled and sent to the Governor. The Governor has until October 20 to sign the bill. Along with SB 208, this bill includes the statutory provisions necessary to implement a new federal Section 1115 waiver. Specifically, this bill contains all of the provisions that relate to the Coverage Expansion and Enrollment Demonstration projects provided for by the waiver.

***AB 542** (Feuer) Hospital Acquired Conditions
This bill was vetoed by the Governor. This bill would have required the Department of Health Care Services (DHCS) and MRMIB to implement nonpayment policies and practices for hospital acquired conditions.

***AB 1602** (Perez) Health Care Coverage
This bill was signed into law by the Governor. Along with SB 900, this bill enacts the necessary laws to establish an American Health Benefit Exchange in California consistent with the federal Patient Protection and Affordable Care Act (PPACA). Specifically, this bill sets forth the authorities and duties of the California Health Benefit Exchange necessary to implement specific functions as required by PPACA

AB 1653 (Jones) Medi-Cal: Hospitals: Managed Health Care Plans: Quality Assurance Fee
This bill was signed into law by the Governor. This bill makes the necessary changes to the quality assurance fee established by AB 1383 (2009) needed to gain approval by the Centers for Medicaid and Medicare Services (CMS) for the increased federal match. A total of $80 million per quarter of the proceeds from the fee are required to be paid for health care coverage for children.

***AB 2244** (Feuer) Health Care Coverage
This bill was signed into law by the Governor. This bill requires guaranteed issue of health plan and health insurance contracts for children, as required by the federal Patient Protection and Affordable Care Act (PPACA). Beginning in 2011, if health plans fail to issue child-only plan contracts, they will be prohibited from issuing all individual market plan contracts for five years.

***AB 2470** (Del La Torre) Individual Health Care Coverage
This bill was signed into law by the Governor. This bill prohibits a health plan or health insurer from rescinding or canceling a health plan contract/health insurance policy.

SB 208 (Steinberg and Alquist) Medi-Cal: Demonstration Project Waivers
This bill has been enrolled and sent to the Governor. The Governor has until October 20 to sign the bill. Along with, AB 342 (Perez), this bill includes the statutory provisions necessary to implement a new federal Section 1115 waiver. Among other things, this bill allows for the

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* Legislation enacting components of federal health care reform under the Patient Protection and Affordable Care Act (PPACA).

establishment of organized health care delivery systems for children eligible for services under the California Children Services (CCS) program, which could include Healthy Families Program (HFP) children.

***SB 890** (Alquist) Health Care Coverage
This bill was vetoed by the Governor. This bill would have required health plans and health insurers to categorize all individual market products into one of five tiers based on actuarial level from catastrophic to platinum levels with an actuarial value upwards of 90 percent.

***SB 900** (Alquist) California Health Benefits Exchange
This bill was signed into law by the Governor. Along with AB 1602, this bill enacts the necessary laws to establish an American Health Benefit Exchange in California consistent with the federal Patient Protection and Affordable Care Act (PPACA). Specifically, this bill sets forth the governing structure of the Exchange as an independent public entity within state government.

***SB 1163** (Leno) Health Care Coverage: Denials: Premium Rates
This bill was signed into law by the Governor. This bill requires health care service plans (health plans) and health insurers to file with their regulators specified rate information at least 60 days prior to implementing any rate change for individual and small group plans and to justify unreasonable rate increases as required under the Patient Protection and Affordable Care Act.

SB 1431 (Simitian) County Health Initiative Matching Fund
This bill was vetoed by the Governor. This bill would have allowed C-CHIP counties participating in CHIM (County Health Initiative Matching) Fund to apply to the Managed Risk Medical Insurance Board for receipt of matching federal funds to provide health care coverage to eligible children whose family income is at or below 400 percent of the federal poverty level.

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* Legislation enacting components of federal health care reform under the Patient Protection and Affordable Care Act (PPACA).

Assembly Bills Signed Into Law

***†AB 1602** (Perez) Health Care Coverage
Version: Amended 8/20/2010
Sponsor: Author
Status: ***9/30/2010-SIGNED into law by the Governor. Chapter 655, Statutes of 2010.***

Along with SB 900, this bill enacts the necessary laws to establish an American Health Benefit Exchange in California consistent with the federal Patient Protection and Affordable Care Act (PPACA). The Exchange is intended to provide an organized, transparent marketplace where individuals and small employers can purchase qualified products and claim available federal tax credits and cost-sharing subsidies. Specifically, this bill sets forth the authorities and duties of the California Health Benefit Exchange necessary to implement specific functions as required by PPACA The governing structure of the Exchange is set forth in SB 900 which was also signed by the Governor.

†**AB 1653** (Jones) Medi-Cal: Hospitals: Managed Health Care Plans: Quality Assurance Fee
Version: Amended 8/27/2010
Sponsor: Author
Status: ***9/8/2010-SIGNED into law by the Governor. Chapter 218, Statutes of 2010.***

This bill made the necessary changes to the quality assurance fee established by AB 1383 (2009) in order to gain approval by the Centers for Medicaid and Medicare Services for the increased federal match. AB1383 required DHCS to use the increased federal match provided by the American Reinvestment and Recovery Act for supplemental reimbursements to hospitals and managed health care plans and to provide $80 million per quarter of the year for health care coverage for children. It is possible that a portion of these funds could be allocated in future budgets to HFP.

***†AB 2244** (Feuer) Health Care Coverage
Version: Amended 8/20/2010
Sponsor: Health Access California
Status: ***9/30/2010 – SIGNED into law by the Governor. Chapter 656, Statutes of 2010.***

This bill requires guaranteed issuance of health plan and health insurance contracts and prohibits pre-existing condition exclusions or limitations for children beginning as required by the federal Patient Protection and Affordable Care Act (PPACA). Beginning in 2011, if health plans or carriers fail to issue child-only plan contracts, they will be prohibited from issuing any and all individual plan contracts for five years. The bill establishes open enrollment periods for child-only plan contracts and requires, until 2014, that health plans and health insurers limit premium variation due to health status for child-only plan contracts purchased during open enrollment to no more than twice the standard risk rate. The rate for a child-only plan contract purchased

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† Priority Board bills
Developments since the previous Board meeting underlined.

outside an open enrollment period shall be subject to a 20 percent surcharge and shall remain in effect for 12 months. Beginning in 2014, all health plans and insurers will be required use only the standard risk rate when issuing child-only plan contracts.

***AB 2345** (De La Torre) Health Care Coverage: Preventative Services
Version: Amended 8/18/2010
Sponsor: Author
Status: ***9/30/2010 – SIGNED into law by the Governor. Chapter 657, Statutes of 2010.***

This bill requires group and individual health care service plan contracts and health insurance policies to provide coverage, and not impose cost-sharing requirements, for preventive services as specified by the Patient Protection and Affordable Care Act (PPACA).

***†AB 2470** (De La Torre) Individual Health Care Coverage
Version: Amended 8/27/2010
Sponsor: California Medical Association
Status: ***9/30/2010 – SIGNED into law by the Governor. Chapter 658, Statutes of 2010.***

Consistent with the Patient Protection and Affordable Care Act, this bill prohibits a health plan or health insurer from rescinding or canceling a health plan contract/health insurance policy unless there is a material misrepresentation or material omission in the information submitted by the applicant, and the health plan/insurer demonstrates that the applicant intentionally misrepresented or intentionally omitted material information on the application with the purpose of misrepresenting his or her health history in order to obtain health care coverage. This bill also modifies the ability of a health plan or health insurer to cancel or not renew a contract or policy for nonpayment of premiums by requiring a 30-day grace period from the date of notification from the plan or insurer.

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* Legislation enacting components of federal health care reform under the Patient Protection and Affordable Care Act (PPACA).

† Priority Board bills

Developments since the previous Board meeting underlined.

Senate Bills Signed Into Law

SB 543 (Leno) Minors: Consent for Mental Health Treatment
Version: Amended 8/20/2010
Sponsors: National Association of Social Workers, California Chapter; Mental Health America of Northern California; GSA Network; and Equality California
Status: ***9/29/2010 - SIGNED into law by the Governor. Chapter 503, Statutes of 2010.***

This bill allows a minor who is at least 12 years old to consent to outpatient mental health treatment or counseling services if the attending "professional person," as defined, determines the minor is mature enough to participate intelligently in the mental health treatment or counseling services. It requires the involvement of the minor's parents in the treatment or services unless the "professional person" determines, after consulting with the minor, that the parental involvement would be inappropriate.

***†SB 900** (Alquist) California Health Benefits Exchange
Version: Amended 8/19/2010
Sponsor: Author
Status:***9/30/2010 – SIGNED into law by the Governor. Chapter 659, Statutes of 2010.***

Along with AB 1602, this bill enacts the necessary laws to establish an American Health Benefit Exchange in California consistent with the federal Patient Protection and Affordable Care Act (PPACA). The Exchange is intended to provide an organized, transparent marketplace where individuals and small employers can purchase qualified products and claim available federal tax credits and cost-sharing subsidies. Specifically, this bill sets forth the governing structure of the Exchange as an independent public entity within state government. The Exchange will be governed by a five member board consisting of two members appointed by the Governor, two members appointed by the Legislature and the Secretary of Health and Human Services as the fifth, ex-oficio member. The duties and powers of the California Health Benefits Exchange are set forth in AB 1602 which has also been signed by the Governor.

***SB 1088** (Price) Health Care Coverage: Dependents
Version: Amended 8/20/2010
Sponsor: Author
Status: ***9/30/2010 – SIGNED into law by the Governor. Chapter 660, Statutes of 2010.***

This bill prohibits, with specified exceptions, the limiting age for dependents covered by health plan contracts and health insurance policies from being less than 26 years of age, pursuant to the Patient Protection and Affordable Care Act (PPACA).

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† Priority Board bills
Developments since the previous Board meeting underlined.

***†SB 1163** (Leno) Health Care Coverage: Denials: Premium Rates
Version: Amended 8/25/2010
Sponsor: Health Access California
Status: ***9/30/2010 – SIGNED into law by the Governor. Chapter 661, Statutes of 2010.***

This bill requires health care service plans (health plans) and health insurers to file with their regulators specified rate information at least 60 days prior to implementing any rate change for individual and small group plans and to justify unreasonable rate increases as required under the Patient Protection and Affordable Care Act. The bill requires rate filings to be actuarially sound and to include a certification by an independent actuary that any increase is reasonable or unreasonable. The bill increases, from 30 days to 60 days, the amount of time that health plan or insurer provides written noticed to an enrollee or insured before a change in premium rates or coverage becomes effective. The bill also requires health plans and insurers that decline to offer coverage to or deny enrollment for a large group applying for coverage or that offers small group coverage at a rate that is higher than the standard employee risk rate to, at the time of the denial or offer of coverage, provide the applicant with reason for the decision.

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* Legislation enacting components of federal health care reform under the Patient Protection and Affordable Care Act (PPACA).
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Developments since the previous Board meeting underlined.

Assembly Bills Vetoed

***†AB 542** (Feuer) Hospital-Acquired Conditions
Version: Amended 8/17/2010
Sponsor: Author
Status: ***9/29/2010-VETOED***

This bill would have required the Department of Health Care Services to convene a technical working group to recommend nonpayment policies and practices for hospital acquired conditions to the Department by February 1, 2011, and implement nonpayment policies and practices for the fee-for-service Medi-Cal program, in accordance with the Patient Protection and Affordable Care Act (PPACA). MRMIB would then have had to require contracted health plans to implement the nonpayment policies and practices through their contracts with providers.

Governor's Veto Message:

> I am returning Assembly Bill 542 without my signature. It is amazing to think that health care providers and facilities get paid, even when they operate on the wrong patient; give the wrong drug; administer a fatal medical procedure; transmit a preventable infection; or worse. My Administration has tried to enact "non-payment" policies since my health reform effort in 2007. Providers have resisted this commonsense policy for years. So, it is understandably hard for me to veto this measure. However, while I am supportive of stakeholder expertise in the development of California's non-payment policies and procedures for healthcare-acquired conditions consistent with the provisions of federal health reform, legislation is not required for the Department Health Care Services to undertake this process. Nor, given the provider community's significant resistance to implementation of these policies, do I think it would be a worthwhile use of the Department's time. In addition, California needs to enact legislation that consistently applies these non-payment policies to both public and private health coverage while ensuring that no patient bears the fiscal responsibility for these preventable mistakes. Legislation needs to clearly prohibit balance-billing under these circumstances to ensure that health facilities and providers bear the responsibility for their actions.

AB 1600 (Beall) Health Care Coverage: Mental Health Services
Version: Introduced 8/20/2010
Sponsor: Author
Status: ***9/29/2010-VETOED***

This bill would have required health plan contracts and insurer policies issued, amended or renewed on or after January 1, 2011, to cover the diagnosis and treatment of substance abuse and

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† Priority Board bills
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mental illnesses as defined in the American Psychiatric Association's Diagnostic and Statistical Manual IV.

Governor's Veto Message:

> To the Members of the California State Assembly: I am returning Assembly Bill 1600 without my signature. This is the fourth time that I have vetoed this measure. In addition to the concerns that I have consistently cited over the last three vetoes regarding the overall rising cost of healthcare and lack of affordability for employers and individuals struggling to keep their existing coverage, I am now able to add a new concern. The federal health reform provisions that take effect in 2014 will require states to pay the entire cost of mandates that go above and beyond the definition of "essential benefits." This bill certainly requires a higher level of service than contemplated on a federal level and as such, will mandate California to spend new General Fund dollars for these benefits. I cannot agree to a significant expenditure of new funds when we are struggling to provide basic levels of coverage to our most needy and fragile populations.

***AB 1825** (De La Torre) Maternity Services
Version: Amended 8/20/2010
Sponsors: American Congress of Obstetricians and Gynecologists, District IX; California Commission on the Status of Women
Status: ***9/30/2010 – VETOED***

This bill would have required every individual or group health insurance policy issued, amended, or renewed on or after July 1, 2011, and prior to January 1, 2014, to provide coverage for maternity services, as defined and after January 1, 2014, to provide coverage for maternity services consistent with the federal Patient Protection and Affordable Care Act. Currently health care service plans regulated by the Department of Managed Health Care have been required by the Knox-Keene Health Care Service Plan Act to provide maternity services, but health insurers regulated by the Department of Insurance have not. The bill would have defined maternity services to include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care. Although there would have been no direct impact to MRMIB programs because maternity services are already included, to the extent that there are a number of AIM subscribers that simultaneously carry private insurance that does not cover maternity services, there could have been an indirect impact to the AIM program.

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† Priority Board bills
Developments since the previous Board meeting underlined.

Governor's Veto Message:

> I am returning Assembly Bill 1825 without my signature. While I acknowledge the author's effort to address the reason for the last three vetoes on similar measures, the bill continues to represent a significant barrier to affordable coverage. I can appreciate the policy arguments, but none of the organizations lobbying for this bill's passage must represent the individuals and families struggling to pay for their existing health coverage. Nor are any of these organizations offering to help families pay for their increasingly expensive coverage. It is a familiar effort in which supporters demand more and better coverage, until the cost for that coverage is added up. Ironically, some of these same organizations then turn around and blame the health insurance companies for charging too much for the benefits they themselves demanded. I firmly believe you can't have it both ways. The passage of federal health reform will have broad and consequential impacts across our state and nation. Affordability is the one area in which the hard decisions remain unresolved. However, if left unaddressed, the lack of affordability will undermine the entire reform effort. Leaders, at both a national and state level, must accept this responsibility and be willing to make the decisions that are politically unpopular, but represent a long-range solution to the problem. This bill represents a one-sided solution that hurts many hard-working Californians by increasing costs as well as the number of uninsured. For these reasons, I cannot sign this bill.

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* Legislation enacting components of federal health care reform under the Patient Protection and Affordable Care Act (PPACA).

† Priority Board bills

Developments since the previous Board meeting underlined.

Senate Bills Vetoed

SB 56 (Alquist) County Joint Health Plan Ventures
Version: Amended 8/17/2010
Sponsor: Author
Status: ***9/29/2010 - VETOED***

This bill would have allowed health plans governed by various county bodies (boards of supervisors, special commissions, health system, health authority or medical services plan) to form joint ventures to create integrated networks of public health plans that pool risks, share networks or jointly offer health plans to individuals and groups. The intent of the legislation was to facilitate establishment of affordable health coverage options in the individual and group markets.

Governor's Veto Message:

> I am returning Senate Bill 56 without my signature. This bill is unnecessary, as there is nothing in existing law that prohibits a county organized health plan, local initiative or other public entity from entering into a joint venture and seeking licensure with the Department of Managed Health Care. Furthermore, this bill does not solve the underlying problem for why these entities have been unsuccessful expanding their business in the past. For these reasons, I cannot sign this bill.

***†SB 890** (Alquist) Health Care Coverage
Version: Amended 8/25/2010
Sponsor: Health Access California; Kaiser Permanente Medical Care Program
Status: ***9/30/2010 – VETOED***

In accordance with the Patient Protection and Affordable Care Act, this bill would have required health plans and health insurers to categorize all individual market products into one of five tiers based on actuarial level from catastrophic to platinum levels with an actuarial value upwards of 90 percent. The bill would have required health plans and health insurers to allow an individual to transfer without medical underwriting to any other individual plan contract offered by that same health plan or health insurer that provided equal or lesser benefits upon the annual renewal date of the contract or policy. The bill also included some of the PPACA consumer protections such as the prohibition on lifetime limits and restricted annual limits, and the PPACA medical loss ratio and required compliance with any federal rules or regulations issued under those provisions.

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† Priority Board bills
Developments since the previous Board meeting underlined.

Governor's Veto Message:

> I am returning Senate Bill 890 without my signature. While I appreciate the author's leadership and efforts to help transition California's healthcare delivery system in preparation for more significant changes in 2014, this bill creates unnecessary and duplicative costs by requiring health plans and health insurers to meet disclosure requirements in 2011 that will change again in 2014. The added costs for implementing the provisions of this bill outweigh the potential short-term benefits for the two regulatory entities, the affected health plans and consumers. For these reasons, I cannot sign this bill.

†**SB 1431** (Simitian) County Health Initiative Matching Fund
Version: Amended 4/7/2010
Sponsor: San Mateo County
Status: ***9/29/10 – VETOED***

This bill would have expanded eligibility in the County Health Initiative Matching Fund program, also known as C-CHIP, to children in families with income of 300 percent of the federal poverty level up to 400 percent. It would also have authorized eligibility for children who, although they have met the requirements for HFP, are unable to enroll when enrollment caps are utilized due to budget limitations. Pending federal approval, funding for this expansion would have been in accordance with the state's Medicaid matching ratio using one-half local funds rather than state funds and one-half federal matching funds. No state funds would have been used to support this expansion.

Governor's Veto Message:

> To the Members of the California State Senate: I am returning Senate Bill 1431 without my signature. Given the state of the economy, the low participation rate in the current program and the new federal maintenance of effort requirements for the Healthy Families program, expanding eligibility for this local program is not necessary. In addition, the practical impacts of this bill will be short-lived, given that families with eligible children will have the opportunity to purchase subsidized insurance through the health insurance exchange in 2014. For these reasons, I do not believe it is necessary to sign this bill at this time.

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† Priority Board bills
Developments since the previous Board meeting underlined.

Other Bills Enrolled and Sent to the Governor

†**AB 342** (Perez) Medi-Cal: Demonstration Project Waivers
Version: Amended 10/6/2010
Sponsor: Author
Status: ***10/8/2010 – Enrolled***

This bill is one of two companion bills (AB 208 is the other) that include the statutory provisions necessary to implement a new federal Section 1115 waiver. California currently has several waivers, including the Medi-Cal Hospital/Uninsured Care waiver (hospital financing waiver) which will expire in August 2010. This bill contains all of the provisions that relate to the Coverage Expansion and Enrollment Demonstration projects provided for by the waiver. These projects to be proposed by eligible local entities are intended to serve as a bridge to 2014, when the Patient Protection and Affordable Care Act provisions become effective, mandating that Medicaid coverage eligibility requirements expand from 100 percent FPL to 133 percent FPL. Because this bill contains an urgency clause, it was able to be taken up and passed by the legislature following the passage of the budget. Pursuant to the Constitution, the Governor has 12 days to sign or veto the bill. If the Governor fails to take action by October 20, the bill will become law.

†**SB 208** (Steinberg and Alquist) Medi-Cal: Demonstration Project Waivers
Version: Amended 10/7/2010
Sponsor: Author
Status: ***10/8/2010 – Enrolled***

This bill is one of two companion bills (AB 342 (Perez) is the other) that include the statutory provisions necessary to implement a new federal Section 1115 waiver. California currently has several waivers, including the Medi-Cal Hospital/Uninsured Care waiver (hospital financing waiver) which will expire in August 2010. Among other things, the bill would require, in accordance with the waiver, that DHCS establish organized health care delivery systems for children eligible for services under the California Children Services (CCS) program. The bill would permit MRMIB to enroll children in Healthy Families in these organized health care delivery models. Because this bill contains an urgency clause, it was able to be taken up and passed by the legislature following the passage of the budget. Pursuant to the Constitution, the Governor has 12 days to sign or veto the bill. If the Governor fails to take action by October 20, the bill will become law.

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† Priority Board bills
Developments since the previous Board meeting underlined.